PRINTED: 06/24/2011 FORM APPROVED OMB NO. 0938-0391

CELTERS I OF	T OF DEFICIENCIES	Type of the service o	(2/2) 3 (	HEIDI E GG	NOTERICATION	TVAN DATE	GLIDVEN
l	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPI	LETED
		15E245	B. WIN		-	05/23/2	2011
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	ROVIDER OR SUPPLIE	R					
OT 41101	IOTINE LIONE FO	D THE AGED			/EST 86TH STREET		
STAUGU	JSTINE HOME FO	R THE AGED		INDIAN	IAPOLIS, IN46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
K0000							
Koooo							
	A I if Cafet C	d. D	1/20	0000			•
	_	ode Recertification and	K	)000			
	State Licensure	Survey was conducted by					
	the Indiana State	e Department of Health in					
	accordance with	42 CFR 483.70(a).					
		12 22 23 102 1, 1 (11)					
	G D 4 04	-/02/11					
	Survey Date: 05	5/23/11					
	Facility Number	: 000389					
	Provider Numbe	er: 15E245					
	AIM Number: 1						
	Alivi Nullioci.	100288920					
	Surveyor: Mark	Caraher, Life Safety					
	Code Specialist						
	At this Life Safe	ety Code survey, St.					
		•					
	_	e for the Aged was found					
	not in compliance	ce with Requirements for					
	Participation in	Medicaid, 42 CFR					
	Subpart 483.70(	a), Life Safety from Fire					
		ition of the National Fire					
		ciation (NFPA) 101, Life					
	Safety Code (LS	SC), Chapter 19, Existing					
	Health Care Occ	cupancies and 410 IAC					
	16.2.	•					
	10.2.						
	This facilly 1	atad an the case of the f					
	<b>3</b> /	ated on the second and					
	third floor of a tl	hree story building was					
	determined to be	e of Type II (222)					
		I fully sprinklered. The					
	-	e alarm system with					
	smoke detection	in the corridors and all					
	areas onen to the	e corridor. The facility	- 1				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

XM4G21

Facility ID:

000389

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		15E245	B. WING		05/23/2011
NAME OF F	AD CAMPED OF GUIDNIED			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		2345 V	VEST 86TH STREET	
	JSTINE HOME FOR			NAPOLIS, IN46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
IAU		LSC IDENTIFYING INFORMATION)	IAG	DEFICIENCE,	DATE
	1 2	42 and had a census of			
	41 at the time of	this visit.			
Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/31/11.					
	The feeility was	found not in compliance			
	_	found not in compliance ntioned regulatory			
	requirements as	2 3			
	following:	evidenced by the			
	ionowing.				
K0011 SS=E	nonconforming but fire barrier having resistance rating or required for the adopenings occur on protected by appropriate the protection of the fire barrier set the assisted living protection needed barrier. LSC 19. LSC 8.2.3.2.3.1 Inhour fire barrier having at least a rating. This deficiency of the second and of the	a common wall with a at least a two-hour fire constructed of materials as ldition. Communicating ally in corridors and are oved self-closing fire doors.  4.2 ation and interview, the censure 4 of 4 door sets in apparating health care from g occupancy provided the d for a two hour fire  1.1.4.2 refers to LSC 8.2. requires openings in a 2 be provided with doors  1 1/2 hour fire protection cient practice could affect and visitors in the vicinity d third floor dining room access doors and the	K0011	Our Advisory Board are consulting with experts for obtaining fire protection for existing doors, estimate on d replacements and the most effective course of correction The above date is tentative of	ı.

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Event ID: XM4G21 Facility ID:

000389

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	A. BUIL	DING	NSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/23/2011
	ROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE EST 86TH STREET APOLIS, IN46260	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) floor West Corridor door		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	sets.	noor west contact door				
	Findings include					
	facility from 11:3 05/23/11, the sec dining room Cen sets and the secon Corridor door set separating health did not display a rating required for fire wall. Based of observation, the acknowledged not was listed on the	nager during a tour of the 30 a.m. to 2:20 p.m. on ond and third floor ter Stairwell access door and and third floor West is in the fire barrier care from assisted living one and one half hour or each door in a two hour on interview at the time he Maintenance Manager of fire protection rating doors and they did not centation of the fire				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MU A. BUILI		NSTRUCTION 01	(X3) DATE S	ETED	
		15E245	B. WING	ì		05/23/2	011
	PROVIDER OR SUPPLIER			2345 W	DDRESS, CITY, STATE, ZIP CODE EST 86TH STREET APOLIS, IN46260		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	1 '	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
K0018 SS=E	Doors protecting of than required enclosexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered building resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6.  Roller latches are regulations in all heased on observations facility failed to errooms' corridor do positive latching practice could affivisitor in the vicil dining room and room.  Findings include:  Based on observation facility from 11:305/23/11, the seconds two sets of control of the properties of the control of the c	corridor openings in other osures of vertical openings, is areas are substantial use constructed of 1¾ inch wood, or capable of least 20 minutes. Doors in gs are only required to of smoke. There is no closing of the doors. Doors a means suitable for closed. Dutch doors are permitted. 19.3.6.3 prohibited by CMS ealth care facilities. Action and interview, the ensure 2 of 2 dining cloors were provided with hardware. This deficient fect any resident staff or nity of the second floor the third floor dining	K00	018	Quotations for the installation new approved latching mechanisms are being solicit and these will be needed bef definite date for completion of be given. The above date is tentative only.	ed ore a	07/06/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E245		(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/23/2011	
	PROVIDER OR SUPPLIER		STREET A 2345 W	ADDRESS, CITY, STATE, ZIP CODE /EST 86TH STREET IAPOLIS, IN46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Manager acknow	on, the Maintenance rledged each dining room provided with positive e.			
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 properties and/or 19.3.5.4 properties are separated from resisting partitions self-closing and not protective plates the from the bottom of 19.3.2.1 Based on observe facility failed to serving hazardout floor are equipped devices on the dopractice could affine visitor in the vicit the oxygen storage on the second floor. Findings include a. Based on observations are deviced as a second floor.	em option is used, the areas on other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches the door are permitted.  Action and interview, the ensure 2 of 2 doors as areas on the second do with self closing pors. This deficient fect any resident, staff or nity of Room 224 and ge and transfilling room por.	K0029	We are in the process of obtaining quotation for the installation of a self closing mechanism. The above date tentative because we are aw the quotes.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 01	(X3) DATE S COMPL		
		15E245	A. BUI B. WIN	LDING IG	<u>-</u>	05/23/2	011
	PROVIDER OR SUPPLIER			2345 W	ADDRESS, CITY, STATE, ZIP CODE		
ST AUGU	JSTINE HOME FOR	R THE AGED		INDIAN	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		30 a.m. to 2:20 p.m. on					5.112
	_	224 on the second floor					
		are feet in area and					
	_	d cardboard boxes.					
	Room 224 is equ	ipped with one entry					
	door which latch	es into the frame but the					
	entry door is not	equipped with a self					
	_	Based on interview at the					
		on, the Maintenance					
	-	rledged Room 224 is used					
	to store combustible materials, is greater						
		feet in area and the entry					
		ped with a self closing					
	device.	e en a					
	b. Based on obse						
		nager during a tour of the					
	_	30 a.m. to 2:20 p.m. on					
	•	ond floor oxygen storage oom is equipped with one					
	_	latches into the frame					
	•	r is not equipped with a					
		ce. Six liquid oxygen					
	_	were observed in the					
	second floor oxy						
		. Based on interview at					
		vation, the Maintenance					
		ledged the second floor					
	•	nd transfilling room entry					
		ped with a self closing					
	device.	_					
	3.1-19(b)						

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15E245		A. BUII B. WIN	LDING	01	COMPL 05/23/2	ETED	
	PROVIDER OR SUPPLIER		P. WIII	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST 86TH STREET APOLIS, IN46260	<u>I</u>	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0044 SS=E	with 7.2.4. 19.2. Based on observate facility failed to the fire barrier set the assisted living equipped with potthe protection ne barrier. LSC 19. exits to be in acc 7.2.4.3.4 requires barriers be protect LSC 8.2.3.2.1 reconstalled in according addition NFPA 8 Doors and Window closing mechanism so perform the protect of the protect	ation and interview, the ensure 4 of 4 door sets in sparating health care from g occupancy are ositive latching to provide eded for a two hour fire 2.2.5 requires horizontal ordance with 7.2.4. LSC is any opening in fire eted as provided in 8.2.3. Equires fire doors to be edance with NFPA 80. In 0, Standard for Fire lows at 2-1.4.1 requires all losms shall be adjusted to esistance of the latch ositive latching is a door operation. This is a could affect residents, in the vicinity of the floor dining room Center doors and the second and Corridor door sets.	K	0044	We are in the process of obtaining quotation for the installation of a positive latch mechanism. The above date tentative because we are awithe quotes.	e is	07/06/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  01 COMPLETED			
15E245			A. BUILDING	01	05/23/2011
		.0	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/20 11
NAME OF F	ROVIDER OR SUPPLIER			VEST 86TH STREET	
	JSTINE HOME FOR			NAPOLIS, IN46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAU	sets and the second Corridor door set separating health each are not provide latching mechaniat the time of obside Maintenance Ma	nd and third floor West ts in the fire barrier care from assisted living yided with a positive ism. Based on interview servation, the nager acknowledged each equipped with a positive	IAU	District)	DATE
K0050 SS=F	varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement manualible alarms. Based on record facility failed to conducted quarter for 1 of 4 quarter affects all occupations.	s who are qualified to p. Where drills are in 9 PM and 6 AM a coded by be used instead of 19.7.1.2 review and interview, the ensure fire drills were early on the second shift is. This deficient practice ants in the facility ats, staff and visitors.	K0050	At the last week of each mor the maintenance department check to be sure that all Fire for that month were held. Th Maintenance Head will have yearly lop which he maintains stating the date f each month when a fire drill was held.	e will Drills a a s

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E245			(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/23/2011
	PROVIDER OR SUPPLIER		2345 W	NDDRESS, CITY, STATE, ZIP CODE SEST 86TH STREET APOLIS, IN46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	documentation w Manager from 9 05/20/11, there is fire drill being co shift in the third on interview at th the Maintenance drills were condu- of the second qua- requested the 05/ second quarter fire there is no docum	of "Fire Drill Report" with the Maintenance :45 a.m. to 11:30 a.m. on s no documentation of a onducted on the second quarter in 2010. Based ne time of record review, Manager stated two fire acted on the second shift arter of 2010 and had :25/10 second shift re drill be substituted as a drill but acknowledged nentation of a second r fire drill available for			
K0144 SS=C	exercised under lo month in accordant 3.4.4.1. Based on record interview; the fact 1 emergency generates remote manual states emergency lightinstalled, tested a accordance with Emergency and S	spected weekly and and for 30 minutes per noce with NFPA 99.  review, observation and cility failed to ensure 1 of erators is equipped with a top. LSC 7.9.2.3 requires rators providing power to ang systems shall be and maintained in NFPA 110, Standard for Standby Power Systems.  edition, 3-5.5.6 requires	K0144	A remote manual stop has b installed in accordance with Safety Code.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	onstruction 01	(X3) DATE S COMPLI		
		15E245	B. WIN			05/23/20	011
NAME OF I	DROVIDED OD CLIDDLIED		_		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	EST 86TH STREET		
	JSTINE HOME FOR				APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		ions shall have a remote	-	mo	•	1	DAIL
		on of a type similar to a					
	•	on located elsewhere on					
	_	ere the prime mover is					
	-	ne building. NFPA 37,					
		Installation and Use of					
		sustion Engines and Gas					
	· ·	Edition, at 8-2.2(c)					
		of 100 horsepower or					
		sion for the shutting					
	•	at the engine and from a					
	_	This deficient practice					
		ccupants in the facility					
		nts, staff and visitors.					
	meraamg resider	its, starr and visitors.					
	Findings include	:					
	Based on review	of Generator					
		ords on 05/23/11 from					
	9:45 a.m. to 11:3	0 a.m. with the					
	Maintenance Ma	nager, the emergency					
		l at 90 kilowatts or 120					
	-	was installed in August					
	•	observation of the					
		rator equipment during a					
		y from 11:30 a.m. to 2:20					
	p.m. on 05/23/11	, a manual stop is located					
	-	y generator but no remote					
		observed at any location					
	_	y. Based on interview at					
		vation, the Maintenance					
		ledged the facility does					
	_	e manual stop for the					
	emergency gener	-					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPI 05/23/2	LETED
	PROVIDER OR SUPPLIER			2345 W	.DDRESS, CITY, STATE, ZIP CODE EST 86TH STREET APOLIS, IN46260	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
	3.1-19(b)						